

MATERNAL AND INFANT SUPPORT SERVICES PROGRAM

Authorization and Consent to Release Protected Health Information

The Maternal Support Services (MSS) and Infant Support Services (ISS) Programs are designed to provide you with information and referrals to agencies that may help you stay healthy and care for you and your infant. To do this, **we would like you to answer some questions to help us understand your** daily living habits and to identify potential health risks to you and your infant.

The answers that you give to the following questions are protected health information and will be kept confidential unless we are permitted or required by law to release them. In order to plan and provide the best possible care for you and your infant, we may need to share the answers that you give with various health and social services professionals in the Michigan Department of Community Health (MDCH) and the local Family Independence Agency (FIA). To assure that program services are coordinated with your primary health care, we may also need to provide information regarding services you receive, or need to receive, with your physician and other community agencies.

If you qualify for program services, your participation will be completely voluntary. You may refuse to answer any questions that you do not wish to answer. You are free to end the interview at any time. If you decide not to answer some of the questions or if you decide to end the interview, it will not affect your Medicaid eligibility or your ability to receive MSS or ISS for you or your infant.

I have read the above or have had it read/explained to me. I understand that I may qualify to receive MSS or ISS.

- ☐ I **do not** wish to participate in the MSS or ISS assessment and do not want to receive MSS or ISS for myself or my infant.
- ☐ I **do** wish to participate in the MSS or ISS assessment and want to receive MSS or ISS for myself or my infant. I also authorize the release of information to other community agencies to assist in my care.

Print Beneficiary's Name

Beneficiary's Signature

Date

Name of Interviewer

Date